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MEMORANDUM

TO:	House Health Policy Committee
FROM:	Health Care Association of Michigan (HCAM)
RE:	Nursing Facility Employment of Physicians – HB's 5375, 5376 and 5377 Paid Dining Assistants – HB 5389
DATE:	March 25, 2014

Representative Haines, committee members my name is Carolyn Anderson. I am with NexCare Health Systems headquartered in Brighton, Michigan. NexCare operates 17 nursing and rehabilitation facilities throughout the state. I also serve as the current board chair of the Health Care Association of Michigan. Thank you for the opportunity to discuss House Bills 5375, 5376 and 5377 addressing the issue of proprietary nursing facilities directly employing physicians and HB 5389 regarding paid dining assistants.

HCAM is seeking clarification to the "learned professions" doctrine, also known as the "corporate practice of medicine" doctrine that prohibits proprietary nursing facilities from directly hiring physicians for resident care. The principle arose in the 19th century in common law that a corporation may not offer professional services to the public.

One of the philosophical underpinnings of the learned professions doctrine has been concern that profit motive will corrupt the purity of professionalism that society deserves, which has contributed to an exception to the Michigan doctrine.

Michigan's doctrine is based on an Attorney General opinion that stated a nonprofit corporation, not being formed to make profit, might safely offer professional services through employment and a business corporation could not. Thus, in the extended care world, Michigan has an odd dichotomy: nonprofit institutions may hire their own physicians, while proprietary entities cannot.

House Bill 5375 amends the Public Health Code to establish that a nursing facility's license includes within its scope not only room, board and nursing care, but physician care. House Bill's 5376 and 5377 amend the Business Corporation Act and Limited Liability Company Act to allow an exception to the "learned profession" doctrine for nursing facilities to hire physicians.

The Public Health Code, the Business Corporation Act 284 and Limited Liability Company Act 192 intersect unexpectedly when a for-profit nursing facility, seeks to truly integrate physician services through direct employment. Under the Public Health Code, the state routinely issues nursing facility licenses to Act 284 corporations, who offer professional nursing services. That Code also requires that nursing facilities provide medical (physician) services. If an Act 284 nursing facility can't offer physician services directly to its patients, then the objectives of the Public Health Code are obstructed.

The language of Act 284 therefore may not require that institutional and professional services be separated, but offers a clear path to the efficient hiring of physicians by nursing facilities.

Accountable Care Organizations, Managed Care for "Duals," Complex Medical Treatment

Initiatives in the Patient Protection and Affordable Care Act ("PPACA") intensified the federal movement from compartmentalized health care, calling for the creation of Accountable Care Organizations (ACO) and managed care for the "dual" eligibles. At root, ACOs serve the same goal in integrating institutional and professional services, with interdisciplinary sharing of case management. For nursing facilities, it means careful management of hospital readmissions, working with their ACO "partners" to minimize returns to hospital inpatient settings.

Similarly to the ACO's, the impetus behind integrated care for "dual" eligibles is the integration and coordination of patient care transitions through the different health care settings. Managed care organizations will be looking for step down alternatives to hospital stays and competent providers capable of caring for complex physical conditions out of the hospital setting. Nursing facilities will have to develop clinical specialties and improve existing clinical skills.

Further, the residents in nursing facilities today have come to resemble those in general hospitals two decades ago, requiring more specialized therapy and complex medical treatments. Nursing facilities are reaching the limits of the traditional model of independent physician services in their facilities. An obvious step is to follow the lead of many hospital systems, and add physicians known as "hospitalists" to the employed staff, where, free of the competing obligations of private practice, physicians concentrate on developing coordinated care.

Nursing facilities across the country are starting to explore this option as well. Hiring what is affectionately called a "SNFist." This will allow for meaningful care...physicians in facilities on a daily basis will get to know residents and families very well. They will identify immediately a decline in a resident's health and start treatment before it becomes acute and potentially avoid a hospitalization. Preventing hospitalizations is key, as it not only provides better care, but saves Medicare and Medicaid dollars.

The healthcare landscape is significantly changing. Nursing facility providers need tools in the tool box...ultimately, this option will lead to the facility physicians, the primary-care doctors and hospitals working together as a unified team to ensure the best care.

I would also like to speak to House Bill 5389 which amends the Public Health Code to allow utilization of paid dining assistants in nursing facilities. House Bill 5389 would implement federal nursing facility regulations that were established as an option in 2005. The federal regulations outline the training and rules necessary to utilize paid dining assistants to enhance the dining experience of long term care residents who may need nutrition and/or hydration encouragement to promote optimal resident outcomes. Paid dining assistants provide one-on-one attention during meal and snack times for residents whose conditions do <u>not</u> include complicated feeding needs.

At least 28 states have successfully implemented a paid dining assistant program consistent with the federal regulatory requirements referenced above. In 2007, the federal agency with oversight responsibility for skilled nursing facilities further enhanced the regulations to provide for robust monitoring of dining assistant programs through the annual comprehensive survey process that measures nursing facility performance on a continuous basis.

In general, facility-based paid dining assistant programs recruit and provide specialized training to an appropriate ratio of non-nursing service staff already employed by the facility with some new hires to augment staff available to assist residents during meal times and snack times.

The program has been evaluated on both the federal and state level. The Centers for Medicare and Medicaid Services and the Agency for Healthcare Research and Quality commissioned a nationwide study to evaluate the federal paid feeding assistant regulation. Results of this study indicate this regulation may serve to increase the utilization of existing non-nursing staff to improve feeding assistance care during meals without having a negative impact on existing nurse aide and licensed nurse staffing levels. Further details of the study can be viewed in The Gerontologist Vol. No. 2, 2007.

Additionally, in 2003, the Michigan Department of Consumer and Industry Services initiated the Nursing Home Dining Assistance Project allowing several nursing facilities in the state to hire dining assistants. Michigan State University evaluated the results of the pilot project. Evaluated outcomes revealed the social dining experience of the residents was enhanced and safety of the residents was protected.

Change is afoot in long-term care. Michigan has entered an era of rapid growth for our aging population and will be challenged along many fronts to provide quality services. As I have mentioned, nursing facilities need as many tools in the tool box as possible to meet this demand. Both options of hiring physicians and dining assistants will aid in this effort.

Thank you!